plerixafor (Mozobil)

Commercial Medical Benefit Drug Policy

For oncology-related indications, medical necessity criteria can be found here: Blue Shield Oncology-Related Medication Policies.

For PPO, Direct Contract HMO, and when applicable, ASO, and Shared Advantage: Please access Evolent's CarePro Provider Portal to submit your request.

Drug Details

USP Category: BLOOD PRODUCTS AND MODIFIERS
Mechanism of Action: Hematopoietic stem cell mobilizer, inhibitor of the CXCR4 chemokine receptor
HCPCS:
J2562:Injection, plerixafor, 1 mg
How Supplied:
24 mg/1.2 mL (20 mg/mL) in a single-dose vial

Condition(s) listed in policy *(see coverage criteria for details)*

- Peripheral Stem Cell Collection and Transplantation

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

Coverage Criteria

The following condition(s) require Prior Authorization/Preservice.

Peripheral Stem Cell Collection and Transplantation

Meets medical necessity if all the following are met:

1. Being used in combination with G-CSF [filgrastim (or biosimilars), or tbo-filgrastim, pegfilgrastim (or biosimilars)] with or without cyclophosphamide or disease-specific chemotherapy

Covered Doses:
Up to 0.24 mg/kg given subcutaneously daily for 4 days (not to exceed a maximum of 40 mg per day)

Blue Shield of California is an independent member of the Blue Shield Association

Coverage Period:
Once per stem cell transplant procedure

ICD-10:
Z52.011, Z52.091, Z94.84

References

1. Mozobil (plerixafor) Prescribing Information. Genzyme Corporation, Cambridge, MA. 9/2023.
2. National Comprehensive Cancer Network. Hematopoietic Cell Transplantation (Version 2.2025). Available by subscription at: www.nccn.org.

Review History

Date of Last Annual Review: 3Q2025
Changes from previous policy version:

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Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee